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FORM APPROVED

OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 10/05/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445479	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF GRAY			STREET ADDRESS, CITY, STATE, ZIP CODE 791 OLD GRAY STATION ROAD GRAY, TN 37615		
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F 000	INITIAL COMMENTS A Recertification survey and complaint investigation #31345, #31484, #31962 and #32213, were completed on August 19-21, 2013, at Life Care Center of Gray. No deficiencies were cited related to complaint investigation #31345, #31484, and #31962. Deficiencies were cited related to complaint investigation #32213 under 42 CFR PART 483.13, Requirements for Long Term Care Facilities.	F 000			
F 279 SS=D	483.20(d). 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview,	F 279	1.) <u>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</u> a.) Resident #157's care plan updated with the correct information specific to resident's DTI of the right heel including problem, goal of a decrease in size and specific interventions used to promote wound healing efficiently and effectively. 2.) <u>Identify resident's that have the potential to be affected by the deficient practice.</u> a.) All residents with DTI and pressure ulcers have the potential of being affected by the alleged deficient practice. b.) DON completed a 100% care plan audit of those residents who have DTI's or pressure ulcers. No further inaccurate care plans noted upon DON observation.	10/05/2013	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Ashley Hae

Executive Director

9-6-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279	<p>Continued From page 1</p> <p>the facility failed to develop a care plan for one resident (#157) admitted with a pressure ulcer of three residents reviewed with pressure ulcers.</p> <p>The findings included:</p> <p>Resident #157 was admitted to the facility on August 2, 2013, with diagnoses including Fracture Femur, Chronic Airway Obstruction, Esophageal Reflux, Hypertension, Osteoporosis, and Vitamin D Deficiency.</p> <p>Medical record review of the Initial Data Collection Tool/Nursing Service dated August 2, 2013, revealed a deep tissue injury (DTI) located on the right heel. Review of the Nurses Note dated August 2, 2013, revealed "...discoloration noted to R. (right) heel..."</p> <p>Review of the Pressure Ulcer Status Record dated August 2, 2013, revealed the DTI measured 3.0 x (by) 1.0 x 0.0 centimeters (cm). Continued review of the Pressure Ulcer Status Record dated August 12, 2013, revealed the wound measured 2.0 x 0.5 cm, a decrease in size from the initial measurement.</p> <p>Review of the Treatment Record for August 2013 revealed "...Apply skin prep to right heel daily..."</p> <p>Review of the Care Plan dated August 15, 2013, revealed "...Resident is at risk for developing pressure ulcer..." Continued review revealed no information regarding the identification of the area currently being treated on the right heel.</p> <p>Interview with the Minimum Data Set Coordinator on August 21, 2013, at 9:10 a.m., at the 200 hall nurse's station confirmed the Care Plan had not</p>	F 279	<p>3.) <u>What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur?</u></p> <p>a.) MDS coordinator re-educated on the importance of an accurate care plan that furnishes the highest practicable physical well-being of each resident.</p> <p>b.) 100% of the licensed associates were re-educated on the importance of an accurate care plan by the MDS coordinator.</p> <p>4.) <u>How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?</u></p> <p>a.) The DON/designee will check the care plans weekly during the "resident's at risk" meeting that include all pressure ulcers and DTI's, for three months.</p> <p>b.) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.</p>		

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F 279	Continued From page 2 been developed to include the care of the area identified on the right heel at admission. Continued interview confirmed the Care Plan did not reflect the specific identification of the wound area on the right heel and the treatment provided.	F 279			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary, and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to demonstrate catheterization was necessary for one resident (#94) of forty residents reviewed. The findings included: Resident #94 was admitted on August 10, 2012, with diagnoses including Alzheimer's Dementia, Osteoporosis, and Chronic Kidney Disease. Medical record review of a Physician Telephone Order dated July 21, 2013, revealed "...foley catheter (indwelling urinary catheter) 16 french, 30 cc bulb inserted effective date 7/18 D/C 7/21/13." Continued review revealed the order	F 315	1.) <u>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</u> a.) Education provided to both FNP that gave the order for the foley catheter and lpn charge nurse that inserted the catheter, to that when and if an order is given to insert a foley catheter for the diagnosis of urinary retention that as part of "best practice" the amount, color and consistency must be documented. 2.) <u>Identify resident's that have the potential to be affected by the deficient practice.</u> a.) All residents with the diagnosis of urinary retention/ history of urinary retention have the potential of being affected by the alleged deficient practice. b.) DON completed a 100% audit of all resident's with diagnosis of urinary retention. No other residents have been affected by the deficient practice.	10/05/2013	

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F 315	<p>Continued From page 3</p> <p>was signed by the Family Nurse Practitioner (FNP) on July 22, 2013, and "...possible urinary retention."</p> <p>Medical record review of the Nursing Notes dated July 18, 2013, at 4:08 p.m., revealed "...Foley cath (catheter) 16 french, 30 cc inserted using sterile technique. Foley catheter ordered for 24 hour observation for bladder retention..."</p> <p>Record review of the Medication Administration Record for the month of July revealed the resident received one gram of the antibiotic Rocephin IM (Intramuscular) every day for seven days from July 20 - 27, 2013.</p> <p>Medical record review of a FNP note dated July 22, 2013, revealed "Follow-up on pt (patient) with change in mental status and behavior...Bacteremia treated with Rocephin..."</p> <p>Observation in the resident's room on August 21, 2013, at 10:10 a.m., when the Incontinence brief was checked for dryness revealed the resident was cooperative and answered to their name.</p> <p>Interview with the FNP on August 21, 2013, at 10:05 a.m., at the 200 Unit nursing station, concurrent with a review of the FNP's Daily Progress Notes and the Nursing Notes, confirmed the resident was catheterized for possible urinary retention, but the medical record did not document the amount of urine output obtained at the time the indwelling catheter was initiated. Continued interview confirmed the use of the indwelling catheter was originally intended for twenty-four hours, the catheter remain remained in place from July 18-21, 2013, and the resident was treated for a urinary tract infection</p>	F 315	<p>3.) <u>What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur?</u></p> <p>a.) Both FNP and lpn charge nurse educated on urinary retention and foley catheter usage in the form of "best practices."</p> <p>b.) 100% of the licensed nursing associates were educated on the diagnosis of urinary retention and when using catheterization to assist with the diagnosing of urinary retention, that a full and true output has to be obtained, reported and documented. All licensed associates were also educated on the importance of following an md order.</p> <p>4.) <u>How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?</u></p> <p>a.) DON/designee will review all new urinary retention/foley catheter orders and documentation. This will occur in morning clinical meeting each day. Weekend supervisor will notify DON of any urinary retention/foley catheter orders that are written within the weekend, at the time they are written for three months.</p> <p>b.) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education</p>		

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F 315 F 329 SS=D	<p>Continued From page 4 from July 20-27, 2013. 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to prevent an unnecessary drug from being prescribed for one resident (#94) of forty residents reviewed.</p> <p>The findings included:</p>	F 315 F 329	<p>may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.</p> <p>1.) <u>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>a.) All pharmacy recommendations will be signed and written within a 72 hour time frame.</p> <p>2.) <u>Identify resident's that have the potential to be affected by the deficient practice.</u></p> <p>a.) All resident's experiencing weight loss that consume less than 25-50% on average of all meals have the potential of being affected by the alleged deficient practice.</p> <p>b.) Pharmacy consultant reviewed all residents on August 28th and made appropriate recommendations for the reduction/discontinuation of certain medications within the resident's drug regimen.</p> <p>3.) <u>What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur?</u></p> <p>a.) During the "resident's at risk" meeting, the interdisciplinary team will make recommendations and place them on a physician</p>	10/05/2013	

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F 329	<p>Continued From page 5</p> <p>Resident #94 was admitted on August 10, 2012, with diagnoses including Alzheimer's Dementia, Osteoporosis, and Chronic Kidney Disease.</p> <p>Medical record review revealed the resident was admitted weighing 127 pounds, weighed 110 pounds in May 2013, and 106 pounds in June 2013.</p> <p>Medical record review of Physician's Standing Orders revealed "Weight Loss: Elderton 15 ml (milliliters) PO (by mouth) THREE TIMES DAILY, or MedPass supplement 60 ml PO TWICE DAILY, or as ordered."</p> <p>Medical record review of the Physician Telephone Orders revealed an order for Periactin 4 mg (milligram) by mouth daily written on June 14, 2013, by the Family Nurse Practitioner (FNP).</p> <p>Medical record review of the Pharmacist Consultation Report dated June 26, 2013, revealed "Recommendation: Please re-evaluate continued Cyproheptadine HCL (Periactin/antihistamine) use and consider discontinuation or alternative therapy. Rationale for Recommendation: The 2012 American Geriatrics Society Beers Criteria recommends avoiding the use of Cyproheptadine HCL (Periactin) due to its strong, sedating anticholinergic properties (e.g. dry mouth, blurred vision, urinary retention, tachycardia, and toxic psychosis) and decreased clearance in advanced age. The quality of evidence is reported as moderate-high and the strength of their recommendation is strong."</p> <p>Continued review of the Pharmacist Consultation</p>	F 329	<p>communication sheet. At the end of of the meeting the DON/designee will call and speak directly with the medical director/designee and obtain orders for any interventions requested.</p> <p>4.) <u>How the corrective action will be monitored ensure the deficient practice will not recur and what quality assurance program will be put in place?</u></p> <p>a.) Audits will be completed during the RAR meeting once weekly by DON/designee, for three months.</p> <p>b.) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.</p>		

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F 329	<p>Continued From page 6</p> <p>Report revealed "Physician's Response: I accept the recommendation(s) above, please implement as written...D/C (discontinue) Cyproheptadine." Review revealed the FNP signed the Physician Response and added the discontinuation order on July 2, 2013.</p> <p>Medical record review of a Physician Telephone Order dated July 7, 2013, revealed "Discontinue Cyproheptadine HCL (Periactin) 4 mg per pharmacy recommendations. Record review revealed this order was written eleven days after the recommendation was made and five days after the FNP wrote the initial order to discontinue the drug.</p> <p>Observation in the resident's room on August 20, 2013, at 8:25 a.m., revealed the resident in bed, lying on right side asleep, and aroused briefly to their name. Observation revealed the resident's breakfast was placed in front of the resident on the overbed table, but remained untouched.</p> <p>Interview with the FNP on August 21, 2013, at 9:50 a.m., at the 200 Unit nursing station confirmed the resident had not been prescribed MedPass or Eldertonc (as listed on the Standing Orders) prior to Periactin being initiated to address weight loss. Continued interview confirmed the unnecessary drug was not discontinued until eleven days after the Pharmacist listed the adverse effects of the drug in the elderly on the June 26, 2013, Pharmacist Consultation Report.</p> <p>Interview in the hallway (adjacent to the conference room) on August 21, 2013, at 11:00 a.m., with the Medical Director revealed confirmed the use of Periactin for the resident for</p>	F 329			

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F 329	Continued From page 7	F 329			
F 431 SS=D	<p>twenty-three days, from June 14 - July 7, 2013, was unnecessary.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431	<p>1.) <u>What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>a.) Narcotic count sheets are audited daily by unit managers/weekend supervisor. The emergency box locked and replaced by the pharmacy after finding. The expired blood tubes were removed and then replaced with new tubes. The staff development door shut and locked after finding exposed needle syringes.</p> <p>2.) <u>Identify resident's that have the potential to be affected by the deficient practice.</u></p> <p>a.) All resident's residing within the facility have the potential of being affected by the alleged deficient practice.</p> <p>3.) <u>What measures will be put into place or what systematic changes will you make to ensure the deficient practice does not recur?</u></p> <p>a.) 100% of the licensed associates were re-educated on drug records, label/storage of drugs and biologicals. Particular attention was emphasized on the above specific findings.</p>	10/05/2013	

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F 431	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation medical record review, review of facility policy, and interview, the facility failed to maintain accurate narcotic medication reconciliation counts, and documentation of narcotic reconciliation for one of four refrigerator narcotic storage boxes of five boxes observed, failed to secure an emergency medication box, failed to maintain sanitary conditions and had expired laboratory blood tubes available for resident use in one of four medication storage rooms observed; and failed to secure opened needle syringes in the staff development room.</p> <p>The findings included:</p> <p>Review of facility investigation documents dated July 29, 2013, revealed "...on July 28, 2013, at approx. (approximately) 8 p.m., the narcotic count on station 4...from night shift on July 25, 2013, to Day Shift on July 28, 2013, each nurse that worked did not verify meds (medications) that are kept in the refrigerator...all verify...the count on the cart (floor medication cart) was correct but they did not go to the refrigerator to see if the three medications that were supposed to be there were indeed there...drug was a prn (as needed) not used since receipt on April 20, 2013...M.D. (Medical Doctor)...Police notified..."</p> <p>Continued review of the facility investigation documents revealed from July 25, 2013, at 7:00 p.m. until July 28, 2013, at 7:00 p.m. five different facility Nurses counted narcotics in the nursing station involved in the incident, each Nurse signed off the narcotic counts in the both the floor medication cart and the refrigerator narcotic</p>	F 431	<p>4.) <u>How the corrective action will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put in place?</u></p> <p>a.) The Unit managers/weekend supervisor completes a daily audit on narcotic flow sheets, verifying both on coming and off going charge nurses. DON completes compliance rounds noting particular attention to unsecured items within offices and cart compliance checks. Unit managers are now responsible for ordering and replacing lab supplies and monitoring e-box security, need will be noted within the med rooms during a daily check. Audits will be completed one a week for three months.</p> <p>b.) The performance improvement committee will review the results. If it is deemed necessary by the committee, additional education may be provided; the process evaluated /revised and/or the audits reviewed, for three months or until 100% compliance is achieved.</p>		

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F 431	<p>Continued From page 9 storage box as being correct.</p> <p>Review of the facility Destruction Inventory Logs dated July 26, 2013, revealed the missing Ativan gel syringes were not destroyed by the Consultant Pharmacist.</p> <p>Interview with Licensed Practical Nurse (LPN #7) on August 20, 2013, at 8:35 a.m., in the 400 unit nursing station revealed LPN #7 was on duty on July 25-28, 2013, and was responsible for management of the narcotic medications on the unit each of those days during the 7:00 a.m. to 7:00 p.m. shift. Continued interview confirmed LPN #7 failed to visualize the Ativan gel syringes stored in the facility refrigerator during the shift change narcotic counts on Thursday July 25, 2013, Friday July 26, 2013, and Saturday July 27, 2013. Continued interview revealed on July 28, 2013, during the shift change narcotic count LPN #7 opened the refrigerator storage box in the presence of LPN #8 and discovered the medication was missing. Continued interview revealed after a facility investigation of the incident, LPN #7 was suspended and reprimanded. Continued interview confirmed LPN #7 had failed to follow the facility policy for narcotic reconciliation and for documentation of narcotic counts.</p> <p>Interview with LPN #8 on August 20, 2013, at 9:08 p.m., by telephone revealed LPN #8 was on duty July 26, 2013, on the night shift, counted medications with LPN #7, and during the narcotic count failed to visualize the narcotic medications stored in the unit refrigerator during the count. Continued interview confirmed LPN #8 was reprimanded by the facility for failure to follow facility policy related to narcotic counts.</p>	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445479	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF GRAY			STREET ADDRESS, CITY, STATE, ZIP CODE 791 OLD GRAY STATION ROAD GRAY, TN 37615		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 10</p> <p>Continued interview confirmed LPN #8 had failed to follow facility policy related to narcotic reconciliation and documentation of narcotic counts.</p> <p>Interview with LPN #9 on August 20, 2013, at 6:05 p.m., by telephone revealed LPN #9 was on duty July 24 - 25, 2013, and was the last Nurse to visualize the missing medications in the presence of a peer, which occurred on July 24, 2013. Continued interview revealed on July 25, 2013, LPN #9 counted the medications in the refrigerator narcotic storage area alone and documented them to be present. Continued interview with LPN #9 confirmed the LPN violated facility policy for narcotic reconciliation on July 25, 2013. Continued interview confirmed LPN #9 was reprimanded by the facility for failure to follow policy on narcotic medication counts.</p> <p>Interview with LPN #10 (Unit Charge Nurse) on August 20, 2013, at 9:00 a.m., in the 400 wing nursing station revealed LPN #10 was on duty and accountable for narcotic reconciliation on July 25, 2013, on the evening shift with LPN #9. Continued interview revealed LPN #10 failed to visualize the medications in the refrigerator narcotic storage area during the medication count. Continued interview confirmed LPN #10 had failed to follow facility policy related to narcotic reconciliation and documentation of narcotic counts.</p> <p>Interview with the Administrator and the Vice President of Clinical Operations on August 20, 2013, at 3:45 p.m., in the Administrator's office confirmed multiple staff members had failed to follow the facility policy for narcotic reconciliation and control of narcotic medications.</p>	F 431			

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF GRAY			STREET ADDRESS, CITY, STATE, ZIP CODE 791 OLD GRAY STATION ROAD GRAY, TN 37615		
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F 431	<p>Continued From page 11</p> <p>Observation on August 22, 2013 at 8:39 a.m., in the 400 wing Medication Room revealed the emergency medication stock box unsealed and open. Continued observation revealed two blue plastic emergency medication stock box seals lying on the floor. Continued observation revealed a clump of dried bread on the floor. Continued observation revealed twelve green top lab chemistry tubes with expiration dates of June 2013 available for resident use.</p> <p>Review of facility policy, Medication Storage and Security in the Facility, revised June of 2008 revealed "...medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier..."</p> <p>Interview with the 400 Wing unit manager on August 22, 2013, at 8:41 a.m., confirmed the emergency medication stock boxes were to be sealed with a red seal and replaced by the pharmacy after use, confirmed the presence of dried bread in the floor, and the lab tubes were expired and available for resident use. Continued interview confirmed the facility had failed to follow facility policy regarding the storage of medications and biologicals.</p> <p>Observation on August 20, 2013, at 9:00 a.m., in the staff development room revealed the door was unsecured. Continued observation revealed on a cart in the room were 3 boxes of needle syringes and some loose butterfly needles.</p> <p>Interview with Unit Manager #1 on August 20, 2013, at 9:05 a.m., in the staff development room</p>	F 431			

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF GRAY			STREET ADDRESS, CITY, STATE, ZIP CODE 791 OLD GRAY STATION ROAD GRAY, TN 37616		
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F 431	Continued From page 12 confirmed the door to the needle supplies was to be secured. C/O #32213	F 431			